

2001 Open Enrollment for 2002

Deputy Sheriff COBRA or Retiree Benefits Participant with Medical-Vision Only

This guide explains your benefits and changes to them in 2002, plus the changes you can make to your coverage during this open enrollment. The guide includes a Resource Directory listing whom to contact if you have any questions (page 8), plus the forms you need to make changes (pages 9-12).

During open enrollment you may:

- Change medical-vision plans
- Add new eligible family members for coverage
- Drop currently covered family members from coverage.

Please review the guide and if you decide to make changes, return the forms **by Friday, November 30** to:

Associated Administrators, Inc.
PO Box 3988
Portland OR 97208-3988

If you decide to keep the same coverage in 2002, do nothing -- simply keep all materials for reference.

This guide is not a complete description of each plan. More details about each benefit are in your plan booklets, available at www.metrokc.gov/ohrm/benefits or in alternate formats from Benefits & Well-Being. Although we've made every effort to ensure this guide is accurate, provisions of the official plan documents and contracts will govern in the case of any discrepancy. As explained in the plan booklets, the benefit program is subject to review and may be modified or terminated at any time for any reason. This guide does not create a contract of employment between King County and any former employee.



King County Office of
Human Resources Management
BENEFITS & WELL-BEING

■ What's Changing in 2002

In 2002, there are cost increases and some changes to the medical-vision plans.

For Regence BlueShield:

- Chemical dependency treatment maximum increases from \$10,326 to \$10,500 in any consecutive 24 months
- Chiropractic care can be directly accessed and no longer requires primary care physician referral
- Oral contraceptives are covered under the prescription drug benefit (effective July 1, 2001).

For PacifiCare:

- Chemical dependency treatment maximum increases from \$10,326 to \$10,680 in any consecutive 24 months
- There is a \$50 copay for smoking cessation.

For Group Health:

- Chemical dependency treatment maximum increases from \$10,326 to \$10,680 in any consecutive 24 months
- The copay for an emergency room visit changes from \$50 (waived if admitted) to \$75 for a network facility (waived if admitted); \$125 for a non-network facility.

■ Cost

Monthly rates for COBRA and retiree rates are based on what King County pays to provide the same coverage for active employees. The following table lists 2001 and 2002 rates. The rate for dependent children applies whether you cover one child or several, as long as you or your spouse also elects self-paid coverage. Add across the row for the family members you cover for your total monthly cost.

Benefit Plan		You	Spouse/DP*	Dependent Child(ren)	Your Total Monthly Cost
Regence BlueShield Medical-Vision	2001	\$ 240.07	\$ 240.07	\$ 209.00	
	2002	\$ 240.07	\$ 240.07	\$ 209.00	
PacifiCare Medical-Vision	2001	\$ 296.90	\$ 237.52	\$ 192.96	
	2002	\$ 329.74	\$ 263.79	\$ 214.31	
Group Health Medical-Vision	2001	\$ 160.93	\$ 182.88	\$ 168.05	
	2002	\$ 218.17	\$ 247.93	\$ 227.82	

Medical-Vision

Do you want to change medical-vision coverage? You may choose from three plan options. The option you select is the option your family members receive.

Plan Feature	Regence BlueShield	PacifiCare	Group Health
Annual deductible	\$100/person; \$300/family	None	None
Copay/office visit	None	\$5	\$7
After deductible/copays, plan pays most covered expenses at ...	80% - 100%	100%	100%
Until you reach your annual out-of-pocket expenses of ... then most expenses are paid at 100% for rest of year	\$375/person (excluding deductible)	\$500/person; \$1,000/family	\$1,000/person; \$2,000/family
Lifetime max	\$1,000,000	No limit	No limit
Requires primary care physician (PCP)	No	Yes	Yes
Additional benefits for LEOFF 1 employees with occupational injuries	None	None	100% ambulance services; no emergency room care copay; 100% skilled nursing facility care up to 30 days/condition
Alternative care	Not covered	100% after \$5 copay/visit	100% after \$7 copay/visit
Ambulance services	80%	100%	80% (100% for LEOFF 1 with occupational injuries)
Chemical dependency treatment	\$10,500 max/24 mos	\$10,680 max/24 mos	\$10,680 max/24 mos
-- inpatient	100%	100%	100%
-- outpatient	100%	100%	100% after \$7 copay/visit
Chiropractic care	100%	100% after \$5 copay when referred by PCP; 100% after \$10 copay/visit up to 33 visits/year when self-referred (must see a network provider)	100% after \$7 copay/visit when medically necessary
Circumcision	100%	100%	100%
Diabetes care training	100%	100%	100% after \$7 copay/visit
Durable medical equipment and diabetic equipment	80%	100%	80%
Emergency care (in an emergency room)	80% after \$25 copay (waived for accidental injury, surgery or if directly admitted)	100% after \$50 copay/visit (waived if admitted)	100% after \$75 copay/visit at a network facility (waived if admitted); \$125 copay/visit at a non-network facility (waived if LEOFF 1 with occupational injuries)
Family planning	Covered at various levels; call plan for details	100%	Covered at various levels; call plan for details
Home health	90% up to 130 visits/yr	100% up to 130 visits/yr	100%

Plan Feature	Regence BlueShield	PacifiCare	Group Health
Hospice care	90% (the greater of 6 mos or \$10,000 lifetime max)	100% (6-month lifetime max)	100% (limits apply; call plan for details)
Hospital care	80% inpatient and outpatient (inpatient subject to pre-admission approval)	100%	100%
Lab, x-rays and other diagnostic testing	100% physician services; 80% hospital services	100% (includes mammograms, prenatal tests)	100%
Manipulative therapy (including chiropractic services)	See chiropractic care	See chiropractic care	100% after \$7 copay/visit
Maternity care			
-- delivery and related hospital care	100% physician services; 80% hospital services	100% after \$10 copay/pregnancy	100%
-- prenatal and postpartum care	100% physician services; 80% hospital services	100% after \$10 copay/pregnancy	100% after \$7 copay/visit
Mental health care			
-- inpatient	100% up to 8 days/yr	100% up to 30 days/yr; 100% residential and day treatment (also subject to inpatient max; each day of care counts as half an inpatient day)	80% up to 12 days/yr
-- outpatient	50% up to 12 visits/yr	100% after \$5 copay/visit up to 30 visits/yr	100% after \$20 copay/individual, family or couple/visit and \$10 copay/group session up to 20 visits/yr
Neurodevelopmental therapy (for children age 6 and under)			
-- inpatient	80% up to \$2,000 annual benefit max	100%	100% up to 60 days/condition/yr
-- outpatient	80% up to \$2,000 annual benefit max	100% after \$10 copay/visit up to 60 visits/condition	100% after \$7 copay/visit up to 60 visits/condition/yr
Newborn care (up to at least 3 weeks as mandated by state law)	100% physician services; 80% hospital services	Covered at various levels; call plan for details	Covered at various levels; call plan for details
Physician and other medical and surgical services*	100% physician services in an office, home, hospital or skilled nursing facility; 100% physician services for surgery; 100% lab and x-ray	100% inpatient; 100% outpatient after \$5 copay/visit	100% inpatient; 100% outpatient after \$7 copay/visit
PKU formula	100%	100%	100%

* Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Call the medical plans for more information.

Plan Feature	Regence BlueShield	PacifiCare	Group Health
Prescription drugs			
-- network (must use participating pharmacies)	100% after copay (\$7 generic, \$12 preferred brand name or \$24 non preferred brand name); up to 30-day supply at network pharmacies (copays do not apply against deductible)	100% after \$5 copay/prescription or refill; 30-day supply at network pharmacies	100% after \$5 copay/prescription or refill; 30-day supply at Group Health pharmacy
-- mail order	100% after copay (\$14 generic, \$24 preferred brand name or \$54 non preferred brand name); 90-day supply (copays do not apply against deductible)**	100% after \$10 copay/90-day supply	100% after \$5 copay/30-day supply
Preventive care (such as routine exams and immunizations)	100%	100% after \$5 copay/visit	100% after \$7 copay/visit
Radiation therapy, chemotherapy and respiratory therapy	100% for radiation and chemotherapy; for respiratory therapy see home health, hospice or hospital care sections	100%	100% after \$7 copay/visit
Rehabilitative services			
-- inpatient	100% up to \$50,000/condition	100%	100% up to 60 days/condition/year
-- outpatient	80% up to \$2,000/yr	100% after \$10 copay/visit up to 60 days or visits/condition/yr	100% after \$7 copay up to 60 visits/condition
Skilled nursing facility	100% up to \$50,000/condition	100% up to 150 days lifetime max/condition (must be in place of a hospital stay)	100% for LEOFF 1 with occupational injuries up to 30 days/condition; not covered for LEOFF 2
Smoking cessation -- sessions	75% after deductible; network provider; \$500 lifetime max	100% after \$50 copay/network program	100% network provider; 1 program/yr max
Smoking cessation -- nicotine replacement	Not covered	100% after \$20 copay for each 4-week supply if prescribed by PCP (90-day treatment max)	100% or \$5 copay/30-day supply (whichever is less) for network program
Sterilization procedures	100%	100%	100% after \$7 copay/visit
Supplemental accident benefits	100% up to \$600/injury (deductible does not apply)	Not covered	Not covered
TMJ	Not covered	Not covered	Up to \$1,000 max/person/yr in plan payments; lifetime max of \$5,000/person
Tooth injury	100% physician/dentist/denturist services; 80% hospital services (up to \$600/injury; deductible does not apply)	100%	Not covered

Plan Feature	Regence BlueShield	PacifiCare	Group Health
Transplants (certain transplants/services only)	100% physician and travel expenses; 80% hospital services; (donor organ procurement costs up to \$25,000; travel expenses up to \$2,500/transplant)	100% up to \$500,000 lifetime max	100%
Urgent care	Covered at various levels; call plan for details	100% after \$5 copay/visit	100% after \$7 copay/visit
Vision care			
-- eye exams	100% for 1 exam/calendar yr (deductible does not apply)	100% for 1 exam every 12 mos (participating providers)	100% after \$7 copay for 1 exam every 12 consecutive mos (must use Group Health providers)
-- eyeglasses (frames and lenses)	Allowance/lens (max of 2 separate lenses/calendar yr): Single vision \$20 Bifocal \$30 Trifocal \$40 Lenticular or aphakic \$65 Frames (every 2 yrs) \$30	100% for 1 pair of glasses and frames/person/24 mos (participating providers); 100% to max allowable benefit of \$100 (non-participating providers)	Not covered
-- contact lenses (instead of glasses)	Medically necessary, up to \$100/lens provided only for aphakia or if vision is correctable to 20/70 or better only by use of contact lenses; if cosmetic, single lens allowance applies (deductible does not apply)	100% up to \$100 for standard contacts (benefits limited to once every 24 mos)	Not covered

■ Adding and Deleting Family Members

Do you want to keep the same eligible family members covered under your benefit plans? Do you want to add or drop family members?

The following family members are eligible under your coverage if you enroll them:

- Your spouse/domestic partner (copy of marriage certificate or an Affidavit of Marriage/Domestic Partnership required if not previously submitted; page 11)
- Unmarried children of you or your spouse/domestic partner who are:
 - Under age 23 and chiefly dependent on you for support and maintenance (generally, that means you claim them on your federal tax return). A child may be your natural child, adopted child, stepchild, legally designated ward, child placed with you as legal guardian, child legally placed with you for adoption, or a child for whom you assume total or partial legal obligation for support in anticipation of adoption.
 - Named in a Qualified Medical Child Support Order as defined under federal law and authorized by the plan.

To add family members not previously covered, list them on your open enrollment form and provide all information indicated. Include additional documentation as required (Affidavit of Marriage/Domestic Partnership, QMCSO, etc.).

To delete family members from coverage, complete the delete sections on the back of your open enrollment form and provide all information indicated for each deleted family member. This ensures COBRA information is sent to your deleted family members, as required by law. If you delete a spouse/domestic partner from coverage, complete a Termination of Marriage/Domestic Partnership Statement (page 12).

Resource Directory

Questions About ...	Contact ...
General Benefits	Benefits & Well-Being Yesler Building YES-HR-0500 400 Yesler Way, Seattle WA 98104-2683 Phone 206.684.1556* ■ 1.800.325.6165 x41556* ■ Fax 206.684.1925 kc.benefits@metrokc.gov ■ www.metrokc.gov/ohrm/benefits
COBRA and Retiree Benefits Administration <ul style="list-style-type: none"> Completing forms Premium payments 	Associated Administrators Incorporated PO Box 3988, Portland OR 97208-3988 Phone 1.800.320.2915* ■ Fax 503.727.7444 aaicobra@aai-tpa.com
Medical-Vision <ul style="list-style-type: none"> Providers (doctors, hospitals, pharmacies, mail order prescriptions, etc.) Filing claims Other plan details (covered expenses, limitations, exclusions, preauthorization) 	Regence BlueShield PO Box 21267, Seattle WA 98111-3267 Phone 1.800.544-4246* ■ 206.464.3663* www.regence.com Postal Prescription Services mail order Rx for Regence PO Box 42200, Portland OR 97242-0200 Phone 1.800.552.6694* usmyrrx1@ibmmail.com ■ www.ppsrx.com PacifiCare PO Box 3005, Hillsboro OR 97123 Phone 1.800.932.3004* www.pacificare.com Prescription Solutions mail order Rx for PacifiCare PO box 9040, Carlsbad CA 92018-9040 Phone 1.800.562.6223* www.pacificare.com Group Health PO Box 34585, Seattle WA 98124-1585 Phone 1.888.901.4636* ■ 206.901.4636* info@ghc.org ■ www.ghc.org

* TTY 1.800.833.6388 (Washington Relay Service)

King County Deputy Sheriff COBRA or Retiree Benefits Open Enrollment Form Medical-Vision Only

If you wish to change coverage, please return forms **by Friday, November 30**
to Associated Administrators Inc., PO Box 3988, Portland OR 97208-3988.

No changes? Do nothing -- simply keep all materials for reference.

■ Plan Participant

First Name	MI	Last Name	Birth Date		
Social Security Number		()	Area Code		Phone
Billing Address	Street	Apt No	City	State	ZIP
Home Address	Street	Apt No	City	State	ZIP

■ Covered Family Members

List eligible family members for coverage. Check the box if they're new and attach Affidavit of Marriage/DPship if applicable. Complete back of form if you delete any family members previously covered and attach Termination of Marriage/DPship Statement if applicable.

New	Name	Relationship	Social Security Number	Birth Date	Gender
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					

■ Coverage Options

Check one: ☐ Continue medical-vision only ☐ Drop medical-vision coverage

■ Medical Plan

Check one if you continue medical-vision coverage: ☐ Regence BlueShield ☐ PacifiCare ☐ Group Health

■ Authorization

This form supersedes all other forms. I have read and understand it and open enrollment materials describing my options. The information I provided is true, correct and complete. I hereby certify I remain eligible for COBRA or retiree benefits coverage -- I have not become covered under another group plan. I authorize the insurance carriers to coordinate benefits and process claims for my family and me. I understand the elections I made are binding and cannot be revoked or modified except as explained in the materials provided and until I submit a new form.

Signature _____ Date Signed _____

Affidavit of Marriage/Domestic Partnership

Submit this form with your open enrollment form to document a new marriage or domestic partnership.

■ Check all boxes that apply

- ☐ Add my spouse or domestic partner (DP) for benefit coverage.
- ☐ This form documents my marriage or domestic partnership, but do not add my spouse or DP for benefit coverage at this time.

■ Check one of the following boxes and provide date

- ☐ I (employee) certify my spouse (named below) and I legally married (date) _____.
- ☐ I (employee) certify my DP (named below) and I began our domestic partnership (date) _____ and we:

- Share the same regular and permanent residence
- Have a close personal relationship
- Are jointly responsible for *basic living expenses**
- Are not married to anyone
- Are both 18 years of age or older
- Are not related by blood closer than would bar marriage in the State of Washington
- Were mentally competent to consent to contract when our domestic partnership began, and
- Are each other's sole domestic partners and are responsible for each other's common welfare.

* *Basic living expenses means the cost of basic food, shelter and any other expenses of a DP paid at least in part by a program or benefit for which the partner qualified because of the DPship. The individuals need not contribute equally or jointly to the cost of these expenses as long as they both agree they are responsible for the cost.*

■ Authorization

I understand this affidavit will no longer be effective if my spouse/DP dies or if there is a change of circumstances attested to in this affidavit.

I agree to notify AAI if there is any change of circumstances attested to in this affidavit within 60 days of such change by filing a Statement of Termination of Marriage/Domestic Partnership.

We understand this information will be held confidential and subject to disclosure only upon express written authorization or if otherwise required by law.

We understand this declaration of responsibility for our common welfare may have legal implications under Washington State law.

We understand a civil action may be brought against us for any losses, including reasonable attorney fees, because of a false statement contained in this Affidavit of Marriage/Domestic Partnership.

We certify under penalty of perjury, under the laws of the State of Washington, the foregoing is true and correct.

Participant Signature _____ Date Signed _____

Soc Sec No _____

Spouse/DP Signature _____ Date Signed _____

Spouse/DP Printed Name _____

Termination of Marriage/Domestic Partnership Statement

Submit this form with your open enrollment form to document a divorce or end of a domestic partnership.

■ Check one of the following boxes

- ☐ The termination is due to the dissolution of our marriage Date: _____
- ☐ The termination is due to the termination of our domestic partnership Date: _____
- ☐ The termination is due to the death of my spouse/domestic partner Date: _____

■ COBRA notification address

Provide the address of the deleted spouse/domestic partner (if living) so COBRA information can be mailed as required by law.

Spouse/DP Printed Name _____

Spouse/DP Soc Sec No _____

Address _____

■ Authorization

I (participant) affirm the affidavit of marriage/domestic partnership attested to and signed by me with my former spouse/domestic partner is terminated as of the date indicated above. I understand I must submit this statement of termination to AAI and mail a signed copy to my surviving former spouse/domestic partner within 60 days of the termination or my former spouse/domestic partner will not be given COBRA election rights. I certify under penalty of perjury, under the laws of the State of Washington, the foregoing is true and correct.

Participant Signature _____ Date Signed _____

Soc Sec No _____